KATIE HARTMAN
LFT, LMT
Licensed Esthetician

# Client Intake Form- Facial

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home number _____ Date of Birth _____

Email _____

Have you been under the care of a physician, dermatologist or other medical professional within the past year?
O No O Yes _____

Have you had any of these health conditions in the past or present?
(Please check all that apply and provide additional information in the space provided)

| | | |
|---|---|---|
| o Cancer | o Arthritis | o Immune disorders |
| o Hormone imbalance | o Asthma | o HIV/AIDS |
| o Systemic disease | o Eczema | o Lupus |
| o High blood pressure | o Epilepsy | o Metal bone pins or plates |
| o Spinal injury | o Seizure disorder | o Phlebitis/blood clots |
| o Thyroid condition | o Headaches (chronic) | o Blood clotting abnormalities |
| o Hysterectomy | o Fever blisters | o Psychological treatment |
| o Diabetes | o Hepatitis | o Insomnia |
| o Heart problem | o Herpes | o Keloid scarring |
| o Varicose veins | o Frequent cold sores | o Skin disease/skin lesions |

_____

List any medications/vitamins you take regularly: _____

_____

Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Deferin, Glycolic Acid, Salicylic Acid or Retinol?
O No O Yes, describe:

_____

Do you sunbath or used a tanning bed? O No O Yes
Do you use sunscreen? O No O Yes
Have you ever had an adverse reaction after using any skin care product?
o Rash o Irritation o Peeling o Sun Sensitivity o Breakout

Please list any allergies you have?

_____

Are you pregnant or trying to become pregnant? O No O Yes  Nursing? ? O No O Yes

Which of the following have you had in the past?

o Botox
o Laser hair removal
o Microdermabrasion
o Collagen (fillers)
o Permanent make-up
o Chemical peels

Which of the following best describes your skin type?

o Very oily skin/ large pores
o Combination skin
o Oily in T-zone, dry to normal cheeks
o Dry skin
o Sensitive skin
o Oily skin

Please mark your skin concerns:

o Unwanted hair Area: _____
o Acne
o Discoloration
o Rosacea
o Loss of skin tone
o Dryness
o Sun Damage
o Pigmentation
o Fine lines
o Brown spots
o Wrinkles
o Broken capillaries/veins
o Large pore size

Other concerns? Please list _____

What type of pressure do you prefer for your massage on legs/feet/shoulders/arms?

o Light  o Medium  o Firm

What would you like the focus in your facial today, rate each individual topic 1–5 (5 the most important, 0 the least important)

____Relaxation
____Facial Massage
____Extractions
____Education on Products/Homecare
____Hand/Shoulder/Arm Massage
____Scalp Massage
____Aromatherapy
____Foot/Leg Massage

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the esthetician/skin care therapist of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature: _____ Date: _____